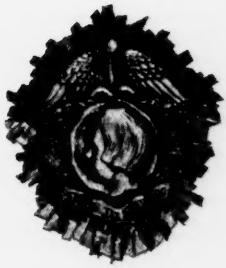
Journal of Dentistry for Children



THIRD QUARTER 1948

Journal of Dentistry for Children

PUBLISHED BY THE AMERICAN SOCIETY
OF DENTISTRY FOR CHILDREN

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PRESIDENT'S MESSAGE

As predicted in my message in the last issue of the Journal there was much therein of interest pertaining to the advancement of Pedodontics in which the A.S.D.C. has had a keen and influential part. The establishment of the Academy of Pedodontics, while not an A.S.D.C. project has been founded soundly by those prominent in the field of pedodontics, members of the A.S.D.C. who will continue to serve the A.S.D.C. faithfully. These two influential organizations will bring even greater advancements in dentistry for children by their assured co-operative efforts.

The recognition of the American Board of Pedodontics by the Council of Dental Education of the A.D.A. last March marked the accomplishment of an A.S.D.C. objective of long standing. The appearance of the By-Laws of the Board in the second issue of the '48 series Journal should be of particular interest to those of the Society interested in the integrity of pedodontics as a specialty.

Without intending this message to be a summary of the last issue of the Journal, I wish to direct the attention of all to Dr. Brauer's article, "Pedodontics Becomes of Age." John has presented a most thought-provoking evaluation of the past, present and future of pedodontics.

The Secretary's message should be most heartening to all interested in the advancement of the Society, and I commend all to co-operate with Dr. Lampshire to the utmost.

The reports of Unit activities in Stan Brown's department "Around the Country" are certainly stimulating with the enthusiasm that is reflected, and are indicative of the opportunities of influence available to the State Units in the advancement of dentistry for children within their own states and dental organizations.

All is in readiness for YOUR 1948 A.S.D.C. meeting at Chicago. Dr. George Teuscher of Northwestern U., our Program Chairman, with Dr. Gerrie of the American Association of Public Health Dentists, has worked out an exceptional program for Sunday, September 12th, at the Stevens Hotel. He has also planned a fine presentation for our luncheon at the BLACKSTONE HOTEL, Monday, September 13th. Dr. Elsie Gerlach, our Chairman of Local Arrangements, has ironed out all the usual problems of such committee function and to these two we are especially indebted.

All Unit Secretaries have been addressed from my office advising them of the necessity of delegate and alternate selection to represent them in the Executive Council session Monday morning September 13th in which Unit problems and society problems will be discussed and the voting rights of the delegates honored. Copies of the schedule of events and the agenda of the Executive Council sessions have been sent to the Unit Secretaries to be delivered to their delegates.

Consult all the data printed herein pertaining to the meeting and your pride in the A.S.D.C. will rise to additional levels, and we will be seeing you in Chicago at the A.S.D.C. meeting!

R. Mott Erwin, Jr.

SEVENTEENTH ANNUAL MEETING, A.S.D.C.

HOTEL STEVENS, CHICAGO, ILLINOIS

September 11, 12 and 13, 1948

PRESIDENT R. M. ERWIN, JR., *Presiding*

At the Stevens Hotel

Saturday, September 11th—9:00 A.M. to 12:00 Noon, Executive Council
Open lunch hour
1:30 to 4:30 P.M., Executive Council

Sunday, September 12th —9:00 A.M. to 12:00 Noon, Joint meeting with A.A.P.H.D.
Open lunch hour
1:30 to 4:30 P.M., Joint meeting with A.A.P.H.D. continued

At the Blackstone Hotel

Monday, September 13th —9:00 A.M. to 12:00 Noon, Executive Council with Unit Delegates
12:30 to 2:00 P.M., Annual luncheon of A.S.D.C. and A.A.P.H.D.
Dental Hygienists and Assistants invited
2:30 to 4:30 P.M., General Business session

AGENDA OF THE EXECUTIVE COUNCIL MEETING

1. Reading of the minutes of the 1948 meeting
2. Presentation of the Presidential report
3. Presentation of the Secretary's report
4. Presentation of the Treasurer's report
5. Presentation of reports of the Editor and Editorial Board
6. Report of Standing Committees
   - A. Local Arrangements: Dr. Elsie Gerlach; not required, but suggestions desired from experiences of this meeting
   - B. Program: Dr. George Teuscher; not required, but suggestions desired from experiences of this meeting
   - C. College, and Question revision of Pedodontics: Dr. John Brauer
   - D. Community Dental Programs for Children: Dr. Hugo Kulstad
   - E. Public Relations: Dr. Jack M. Wisan.
   - F. Membership and States Units: Dr. A. E. Seyler
7. Report of Special Committees:
   - A. Liaison Committee to the A.A.P.H.D.: Dr. Gruebbel
   - B. Liaison Committee to the Council of Dental Health of A.D.A.: Dr. Gruebbel
   - C. Liaison Committee to the A.D.A. Council of Dental Therapeutics: Dr. Paul Losch
   - D. Liaison Committee to the Pediatric Academy and Society: Dr. E. Carl Miller
   - E. Liaison Committee to the American Academy of Pedodontics: Dr. Samuel D. Harris
   - F. American Board of Pedodontics: Dr. Ralph Ireland or Dr. John Brauer
   - G. Constitutional Revision Survey Committee: Dr. Samuel D. Harris; acceptable digest of ideas and report submitted to President Erwin and forwarded to the Committee of Actual Revision
   - H. Constitutional and By-Laws Revision Committee: Dr. Frank Lamons, Dr. Walter McFall and Dr. Hunnicut
8. Old Business
9. New Business
   - A. Reports of nominating committee and auditing committee to be received in later sessions.

PROGRAM

JOINT MEETING
of
The American Society of Dentistry for Children
and
The American Association of Public Health Dentists

Sunday, September 12, 1948 -- Stevens Hotel

9:00 to 12:00 A.M.

Sponsored by the A.A.P.H.D. Dr. Norman F. Gerrie, Chairman.
"The Present Status of Preventive Dental Procedures"
"A Plan for Rendering More Dental Care to Lower Age Groups of the Population"
"An Index of the Prevalence of Gingival Diseases"

1:30 to 4:30 P.M.

Sponsored by the A.S.D.C. Dr. George Teuscher, Chairman.
"Reaction of the Pulp to a Five-Minute Application of Sodium Fluoride to Dentin" by Dr. William E. St. John
"The Calcium Fluoride Ratio in Relation to Dental Caries" by Dr. K. L. Shourie
"The Cranio-Facial Morphology of the Cleft Palate" by Dr. Touro M. Graber

Monday, September 13 -- Blackstone Hotel

12:30 P.M.

Annual Luncheon of A.S.D.C. and A.A.P.H.D.
President R. Mott Erwin, A.S.D.C., presiding.

Speaker: Dr. Edward Ryan, Evanston, Illinois

Subject: "The Case of Mary M."

Dental Hygienists and Assistants are cordially invited to attend our discussion meetings and luncheon.

JOHN T. O'ROURKE, B.S., D.D.S., SC.D.
1888 - 1948

Dr. John T. O'Rourke, Director of Postgraduate Studies at Tufts College Dental School, Boston, died on June 3, 1948, of coronary thrombosis.

Dr. O'Rourke was a graduate of the University of Louisville School of Dentistry and served as Dean of that school from 1926-1944. He was president of the American Association of Dental Schools in 1935, member of the Council on Dental Education from 1938 to 1946, first editor of the Journal of Dental Education (1936-1948) and co-author of *Dental Education in the United States* (1942). Dr. O'Rourke collaborated in the Curriculum Survey Report (*A Course of Study in Dentistry*) in 1935, serving as Secretary of the Curriculum Survey Committee, and he contributed much to the periodical dental literature.

During World War II Dr. O'Rourke gave tirelessly of his time and energies to the war effort, serving as chairman of the Committee on Dentistry, Procurement and Assignment Service, consultant to the Office of Civilian Defense and member of the Committee on Army and Navy Specialized Training Programs.

In recent years, Dr. O'Rourke was particularly interested in the problems of of dental manpower and auxiliary dental personnel. He was a member of the Governor's Commission for a survey of health personnel and facilities in New York State, and recently had completed a similar study of dental personnel needs in North Carolina.

Dr. O'Rourke was a man of exceptional intellectual ability, public health-minded and intensely conscious of dentistry's social responsibilities. His recent investigations in oral physiology and related fields have opened the way to the procurement of knowledge essential to the very basic structure of dentistry as a true health service. These studies will be continued in the Oral Physiology Research Laboratory, which he established at Tufts College, and elsewhere, but Dr. O'Rourke's untimely death is an irreparable loss to the great profession he loved and served so well.

The Role of Oral Foci in Systemic Infection

By CHARLES J. DONNELLY, D.D.S., M.P.H.

EDITOR'S NOTE

Dr. Donnelly is a native of Ann Arbor, graduating from St. Thomas High School in 1938, with awards in football, dramatics and music. His D.D.S. was awarded by the University of Michigan in 1945, and his M.P.H. in 1948, after a hitch in the U.S. Navy.

"Red" recently took unto himself a wife—also blessed with Titian locks—and at present is honeymooning in Northern Michigan.

J.T.H.

Webster [30] gives polemical as one of the meanings of controversial. Polemical comes to the English language from the Greek word "polemikos," meaning warlike, and perhaps this word best describes the dispute about the significance of oral foci in systemic infection that has appeared in the medical and dental literature of the past fifty years.

Curtis [4] has defined focal infection as, "A localized or generalized infection caused by the dissemination of organisms or toxic products from a focus of infection." That this dissemination does occur has been well proven. But the significance of the various foci found in the body and their role in the etiology of certain diseases has not been so clearly defined. Town [28] describes a focus of infection as, "A circumscribed area of disease, necessarily a chronic process, existing in teeth, tonsils, nasal sinuses, gall bladder, appendix, lymph glands, intestinal tract, prostate, or other portion of the human body, which distributes bacteria or toxins through the blood stream or lymphatics."

Rosenow [21] has been the champion of the theory of focal infection and elective localization. But other workers in attempting to repeat his experiments have failed. Wood, [31] in reviewing the literature, cites the efforts of Cusumano, an Italian worker, to develop an elective affinity of streptococci and staphylococci by passing the organism from eye to eye in different series of experimental rabbits. When these bacteria were injected intravenously, lesions occurred throughout the body, in the eyes, liver, joints, kidney, and spleen with slight preference for the eye being shown by streptococci cultivated in brain broth. Nothing suggesting specific organatropism was found. Wood sums up his views as follows: "It is, of course, conceded that bacteria do develop a certain environmental preference, but there is vastly more experimental evidence against oculotropism and the elective affinity of bacteria than there is for those suppositions." "While it is well known that iritis and uvealtract infections may follow the intravenous injection of bacteria in animals, the claim that certain strains of organisms have a selective affinity for ocular tissue is so flimsy that it has no place in court."

In 1928 Holman [20] reviewed the literature on elective localization of bacteria and concluded that the specificity of the bacteria involved had not been proven.

Since these foci of infection may exist in the mouth, the elimination and prevention of them is the responsibility of the dentist. Oral foci are of two types: (1) those associated with the teeth themselves as periapical or pericemental infection, and (2) infection in the supporting soft tissue.

When the internist refers his patient to the dentist, he expects to be informed with some degree of accuracy whether or not oral foci exist. The usual practice is to take a set of full mouth radiograms and make the diagnosis from them. Yet, this step cannot be regarded as a positive or correct diagnosis, for infection may exist in the pulp of a tooth without any radiographic evidence being

present. Ostrander and Crowley [19] found that 52.3 per cent of 487 teeth were infected, which had normal periodontal membranes radiographically. Viridans streptococci were found by Sommer and Crowley [24] in all types of cases, including those in which the bone appeared normal.

Nor is the presence of radiolucent area at the apex of a root definite proof that there is infection there. Sommer and Crowley [24] obtained negative cultures from teeth with all types of lesions demonstrated radiographically. Of forty-five cases diagnosed radiographically as chronic alveolar abscesses, twenty were bacteriologically negative. Ten of the fourteen cases diagnosed by radiogram as granulomas were not infected. Chronic proliferating osteitis was the diagnosis in twenty-two cases and six of the teeth involved were sterile. Of fifteen lesions diagnosed as chronic circumscribed osteitis, four gave no bacterial evidence of infection. In addition, Sommer and Crowley state that, "It is not uncommon to find a tooth in which the periapical tissue appears perfectly normal prior to pulpectomy or treatment, and at the time that the final x-ray film is taken, after filling the canals, to find definite evidence of bone resorption, without infection having been demonstrated." Thus infection can not be diagnosed from a radiogram, nor is pus found in all periapical radiolucent areas.

Much of the experimental work, including that of Rosenow[21], concerning the relation of oral foci to systemic disease, has been based on cultures of extracted teeth. Large percentages of the teeth thus tested were found to be infected. But many workers questioned whether an uninfected tooth could be removed without acquiring mouth organisms accidentally. Tunnicliff [29] demonstrated the fallacy of culturing extracted teeth by a study of sixty-four such teeth. She sterilized their exterior surfaces by searing with a hot instrument, scrubbing and treating with an antiseptic. Then the teeth were cultured for eight days in glucose brain broth. The thirty which showed no growth were opened aseptically and smears, sections and cultures of their pulps were studied. Organisms were isolated from ten of these externally sterile teeth. Since no signs of infection were observed in the smears or sections of the pulps, it was concluded that the bacteria must have entered the pulps by capillary action during the extraction.

Rosenow [21] found 70 per cent of fifty devital teeth with negative radiologic findings heavily infected and 80 per cent of fifty devital teeth with positive radiologic finding heavily infected. Sommer and Crowley[24], using an aseptic technic and taking cultures through the root canal with the tooth in situ secured quite different results. Of forty-five cases with chronic alveolar abscesses, forty of which were devital, twenty were bacteriologically negative. Of twenty-one devital teeth with chronic proliferating osteitis, six were not infected. They also cultured fourteen nonvital teeth with granulomas and found only four of them positive.

In vital teeth with pulp involvements, Ostrander and Crowley [19] found that 49.9 per cent of those experiencing no pain were infected. The percentage of positive cultures was only slightly greater in those cases which had experienced pain.

The most common organisms found in infected root canals were the streptococci. Ostrander and Crowley [19] found 59.6 per cent of root canals infected and the organisms involved follow:

Variety of organisms	20.9%
Streptococcus anhemolyticus	18.3%
Streptococcus viridans	14.4%
Streptococcus hemolyticus	2.3%
Anaerobic streptococcus	1.1%
Bacillus acidophilus	2.1%
Actinomycocses like organism	0.1%

According to Topley and Wilson [27] the two most common organisms found in infected root canals, namely, streptococcus anhemolyticus and streptococcus viridans do not produce any exotoxins. Streptococcus hemolyticus does produce a filterable exotoxin and Topley and Wilson [27] list the following five toxins, or aggressive substances which hemolytic streptococci produce:

(1) streptococcal hemolysin
(2) streptococcal leucocidin

(3) An erythrogenic toxin
(4) A fibrinolysin and
(5) A substance that increases skin permeability. But this organism is found in only slightly more than two per cent of the cases.

Stevens and West [22] have demonstrated that hemolytic streptococci can break down peptones and casein, but do not attack serum or serum albumin. Apparently anhemolytic streptococci and viridans streptococci are incapable of splitting proteins. Topley and Wilson[27] claim that this property of breaking down complex proteins is limited to particular species many of which are anaerobes.

Some workers condemn all devital teeth and do not advocate root canal therapy. However, these men are in the minority and their number is decreasing. Sommer [23], citing the successful root canal therapy of the University of Michigan School of Dentistry, says, "Teeth that have been rendered bacteriologically sterile and hermetically sealed are bound to retain a normal cementum and function physiologically. It has long been recognized that cementum covering the root surface acts as an impenetrable barrier preventing the passage of any foreign material in either direction." Of resected teeth he says, "The complete return of cementum, normal periodontal membrane an alveolar bone around the resected teeth is sufficient proof that services such as this one are biologically sound."

Pulp stones frequently have been associated with infected pulps. However, Sorrin [25] studying this condition, found pulp stones in equal number in vital carious and non-carious teeth. Neman [16] cites cases in which all the teeth contained pulp stones, yet all were vital and had no history of pain. Tunnicliff [29] observed fifty-four teeth with pulpal calcification which were sterile and fifty-eight with pulp stones which also contained streptococci but no signs of infections. The organisms entered the pulp by capillary action during the extraction.

The second possible location of oral foci of infection is in the supporting tissue. The mouth is the normal habitat of a great many bacteria, but when the mucous membranes of the mouth are broken, they provide sufficient protection so as to make the presence of these bacteria unimportant. However, in cases of lowered body defense, poor oral hygiene and pyorrhea, these organisms are able to invade the tissues of the mouth. It must not be assumed from this statement that all cases of pyorrhea and all pyorrhea pockets are infected. Hill [10] says that pus is not a specific feature of pyorrhea in as much as a large majority of periodontal lesion have no visible purulent discharge. When purulent exudate is present and the teeth involved are subject to the trauma of mastication, it would seem possible for bacteria to be pumped into damaged blood or lymph vessels. However, the significance of such a focus is difficult to evaluate. The defenses of the body may be quite capable of disposing of the organism that would be disseminated in the blood stream in this manner.

Pus is the product of the interaction of the body and pyogenic organisms being made up of exudate and dead disintegrating tissue infiltrated with numerous leucocytes. In smears or sections there are large number of leucocytes, large amount of amorphous debris, and cellular fragments.[15] It does not contain living bacteria. Menkin [14] points out that when the pH falls below the level of 6.9 or 6.8, macrophagees and polymorphonuclear cells no longer survive and frank suppuration ensues. Besides pyogenic bacteria and their toxins, aseptic irritants such as turpentine and croton oil will cause typical suppuration.[3]

Pus varies in color, usually being yellow or greenish yellow. The color, some bacteriologists claim, is determined by the organism which produces the inflammation. Karsner [12] says the ordinary pyogenic bacteria produce light yellow pus while P. pyocyanea produces green pus. The identification of organisms by the color of pus produced, however, has been challenged by capable research workers.

Some of the diseases whose etiology has been attributed to oral foci by certain workers are as follows:

(1) Bursitis: However, Curtis [4], in speaking of traumatic bursitis says, "These types of arthritis or joint disease are relatively common, and in so far as we know, have no relationship to in-

fection." Freyberg[7] includes bursitis among the non-articular forms of rheumatism whose etiology is either unknown or is due to trauma.

(2) Osteo-arthritis: Of this disease Freyberg[7] writes, "Since infection plays no part whatsoever in the production of osteo-arthritis, the removal of foci of infection cannot possibly be of any therapeutic importance to the disease process."

(3) Rheumatoid arthritis: After eight years of clinical and laboratory study of a large number of patients, accompanied by animal experiment, Freyberg[7] writes that he has never seen a patient who has had rheumatoid arthritis for more than a year in whom there has been any benefit to the articular disease from the removal of foci of infection from the oral cavity, pharynx, abdomen, or pelvis. In refuting the theory of infection in the etiology of rheumatoid arthritis he reasons as follows: "To prove that a focus of infection causes arthritis the following evidence must exist:
1. A focus must be found consistently. 2. Some substance, such as bacteria, bacterial products or host cell products of inflammation, must get from that focus to the affected parts, that is, the inflamed joints. It has never been shown that there is any toxin that circulates in these patients. An allergen may originate in a localized infection, and an allergic reaction may cause inflammation in joints, but such an allergen never has been shown to exist. 3. The inflammation in the joints must be proved to be the result of "x substance" that gets from a focus to the parts inflamed. Since this three-linked chain of evidence is not supported factually, focal infection as the cause of rheumatoid arthritis remains a theory."

(4) Kidney damage: Haden[8] says that glomerulonephritis is probably always of bacterial origin, frequently occurring in scarlet fever in which the tonsils are the focus. Hill[10] thinks both glomerulonephritis and pyelonephritis may be caused by bacteria from a focus. However, here again it is difficult to determine the significance of oral foci in such diseases.

(5) Valvular heart disease: Taran[25] reports twenty-eight cases of subacute bacterial endocarditis in over 3,000 rheumatic children observed over a ten year period. Ten of these definitely followed dental extractions.

(6) Dermatitis: Good evidence of the relationship of oral foci to skin disease is lacking. But in the opinion of Ormsby and Montgomery[18] focal infection does play a part in the etiology of cutaneous disease. Other dermatologists are skeptical of such a relationship.

(7) Iritis: Of these disturbances Wood[31] has written, "If this theory (focal infection) continues to be accepted in the clinical practice of ophthalmology, such acceptance and practice must be largely on faith. However, it is assumed that there may be a cause-and-effect relationship between a primary focus of infection and ocular disease through such a mechanism as sensitization and intoxication of the diseased eye by bacterial products absorbed from the focus of infection; a fair experimental basis can be advanced for such an assumption, although clinical evidence is lacking."

The principal organisms found in oral foci are the streptococci—mainly streptococcus viridans and streptococcus hemolyticus. If the etiology of certain disease can be attributed to oral foci these organisms are most likely to be involved.

Hayman[9] says, "Infection of the kidney may be caused by almost any organisms. However more than half of the infections are due to Bacterium coli; next in frequency are the staphylococcus and streptococcus, more rarely Proteus vulgaris and Pseudomonas pyocyanea. In rare instances infection of the kidney may result from invasion of Actinomyces and

parasites such as Filaria, Bilharzia or Strongyloids."

The valvular heart diseases of importance are the bacterial endocarditis. According to Kinsella [13], the organisms most often responsible for acute bacterial endocarditis are staphylococcus aureus, streptococcus hemolyticus and pneumococcus. In 90-95 per cent of the cases of subacute bacterial endocarditis nonhemolytic streptococcus is responsible. The gonococcus is next in importance with unidentified gram negative diplococci, staphylococcus albus, streptococcus viridans in combination with streptococcus hemolyticus occurring rarely.

The American Rheumatism Association [1] states that the cause of rheumatoid arthritis remains unknown. As for osteoarthritis this group writes, "As a result of these and similar observations on animals, there is at present a rather widespread belief that the changes which comprise the pathologic picture of the disease are the result of normal wear and tear of everyday use and that it is a natural phenomenon for the joints of men and other animals to develop these changes as age advances."

In 194 cases of eye disorders Wood [31] attributes 10 per cent to syphilis, 49.7 per cent to tuberculosis, 26.1 to focal infection, 7 per cent to gonorrhea, 5.9 per cent to non granulamatous systemic diseases, and 3.2 per cent to miscellaneous and undetermined causes. He also stresses the evidence of recent years that the American ophthalmologists have realized more and more the importance of tuberculosis and brucellosis as the cause of ocular disease.

Curtis [4] points out that although the etiologic factor of acute rheumatic fever is unknown, its distribution has a tendency to follow the distribution of the hemolytic streptococcus. However, the relationship of this organism is probably a hypersensitivity reaction rather than an infection and it is quite unlikely that focal infection in or about the teeth has much to do with the origin of the disease.

Gout is another disease which, in the past, was designated as of unknown origin [1]. Now it is commonly defined as a disturbance of purine metabolism.

The practice of ignoring infected teeth in the child patient cannot be justified. Easlick [5] has expressed the following opinion in a bulletin for the Michigan Department of Health: "Since an abscess about the root of a primary tooth is no different from one about the roots of a permanent tooth, there is every reason to fear and treat both alike. The tissues in the jaws of children are less densely formed than those in the jaws of an adult and children have had little opportunity to build an immunity to a large number of organisms as have adults. If infected teeth cannot be successfully treated, the infection removed, and the teeth safely filled, they had best be removed."

The presence of secondary foci in the body presupposes some means of transportation of the organism from the primary focus—usually the lymph or blood stream. In subacute bacterial endocarditis mouth organisms are thought to get into the blood stream during the extraction of teeth. Taran [26] took blood cultures immediately following the removal of teeth and found streptococcus viridans, but after a lapse of thirty minutes the blood was again sterile. Northrup and Crowley [17] took blood samples at intervals following extractions and found that bacteria remained in the blood stream for only three to five minutes. Elliott [6] noted that the percentage of bacteremias following surgery depended somewhat upon the amount of trauma in the operation and the degree of sepsis in the mouth.

These bacteremias in the normal patient are of little significance since the body defenses are capable of coping with them. Appleton [2] classifies the humoral defenses of the body as either 1. antibacterial—acting against the parasite itself or 2. antitoxic—neutralizing or in other ways rendering innocuous the harmful products of the activity of the parasite. The antibacterial factors act in one of the following ways:

(2) By inhibiting the respiration of the parasite
(2) By causing agglutination of the parasite
(3) By altering the parasite so that it may

be prey to certain types of body cells. —opsonin

(4) By interfering with the free multiplication of the parasite

(5) By killing the parasite—antitoxin, and

(6) By dissolving the parasite—lysin.

Jordan and Burrows [11] list the following antibodies found in immune serum:

(1) Antitoxins
(2) Lysins
(3) Opsonins
(4) Agglutinins
(5) Precipitins
(6) Ablastins
(7) Neutralizing antibodies.

When mouth organisms are swallowed they must face the stomach defenses. Appleton [2] states that the gastric juices are definitely germicidal. In addition to the hydrochloric acid, the sulphocyanide and pepsin probably have some effect on certain types of bacteria. Vomiting also effectively cleans the stomach of infectious material.

The dentist should regard oral foci of infection as potentially dangerous, discover them and remove them as a prophylactic and general health measure. Neither the dentist nor the physician can promise relief from rheumatic conditions following the removal of an oral focus. It appears pertinent to suggest, here, a re-evaluation of past opinion regarding focal infection and the evidence on which practices have been based, and it seems sensible to continue such evaluation throughout the coming decade.

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Gingivitis from the Standpoint of the Physician

FREDERICK F. TISDALL, M.D., F.R.C.P. (LOND.), F.R.C.P. (C.)*

EDITOR'S NOTE

Doctor Tisdall's article appears in our Journal through the efforts of Mott Erwin, who solicited the manuscript as a further tie between pediatric groups and the A.S.D.C.

Doctor Tisdall was born in Clinton, Ontario, graduated from the University of Toronto Medical School in 1916, after which he served overseas in the Canadian Army Medical Corps. After post-graduate work at Johns Hopkins, he returned to his Alma Mater, where he is now Associate Professor of Pediatrics and Director of Research Laboratories, Department of Pediatrics and Hospital for Sick Children.

Author of many scientific articles, this is Dr. Tisdale's "first appearance" in our Journal. We welcome him, and hope he is back again soon!

A.E.S.

Medical dictionaries define gingivitis as "inflammation of the gums." The cardinal symptoms of acute inflammation are heat, redness, swelling and pain. With chronic inflammation there is a building up of new connective tissue.

The first evidence of gingivitis as most frequently seen by the physician is redness and swelling of the gum tissue. The papillae on the labial gingival margins are first involved. As the condition progresses, and it should be emphasized that the progress is usually slow, extending over a period of weeks or months, the redness and swelling become more marked and usually both the papillae and the gingival margin are involved. Sometimes the area of redness will stop at a distinct line at a varying distance from the gingival margin, in other cases all the gingival tissue appears to be affected. As the degree of involvement increases, the papillae may become greatly swollen and reddened. Both the papillae and the tissues at the gingival margins become detached from the teeth and there is obvious pocket formation. Although the redness and swelling of the gingival tissues are typical of an acute inflammatory reaction, the clinical course would normally be classified as chronic, as the appearance of the gum tissue varies only slightly over a period of weeks. Along with the redness and swelling there is frequently bleeding and tenderness on pressure.

In addition to the acute changes, evidences of chronic inflammation are frequently seen. In these cases the outstanding clinical manifestation is a thickening of tissue. The thickening may involve the papillae alone, the rest of the gingival margin, or all the gingival tissues. The condition can usually be differentiated from the acute reddened oedamatous swelling previously described, as this thickened tissue is of a firm, cartilaginous consistency and is pale in color. The interdental papillae are usually lost as a result of previous gingival inflammation.

In contrast to the gingivitis just described are the very acute changes due to "Vincent's infection." The gums are not only red and swollen but are markedly tender. The condition rapidly progresses with systemic symptoms, such as rise in temperature and general debility, and usually results in some necrosis of the gum tissue. Bacteriological examination of smears taken from the mouth show the presence of large numbers of fuso-spirochetal organisms. However, the mere presence of these organisms does not indicate that the patient is suffering from Vincent's infection as these organisms are present in small numbers in normal mouths. Vincent's infection is of rare occurrence compared with the ordinary type of gingivitis previously described. Acute changes may also result from

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other causes, such as virus and streptococcal infections and reaction to certain drugs and heavy metals, such as dilantin, mercury, lead and bismuth.

Before discussing from the standpoint of the physician the different factors involved in the development of gingivitis, the various supporting structures of the tooth, or the periodontal tissues, will be briefly enumerated. Approximately two-thirds of the tooth is encased in the alveolar process of the mandible or maxilla. A fibrous membrane called the periodontal membrane attaches the tooth to the bone. The gingivae or gum tissues overlying the alveolar process and a portion of the tooth are firmly attached to the alveolar process and to the tooth as it projects beyond the alveolar process. The free margin of the gum is not attached to the tooth as there is normally a sulcus up to 2 millimeters in depth between the tooth and the gingiva. It is obvious that anything that tends to produce an irritation, such as calculus formation or the impaction of food, with resultant bacterial growth in the sulcus between the tooth and the gum tissue, will tend to result in inflammation of the gum tissues and an increase in the depth of the sulcus. As the sulcus becomes deeper the periodontal membrane, and eventually the alveolar process, become involved, with resultant loosening of the tooth.

The factors involved in the development of gingivitis may be divided into two main groups, local factors and systemic factors. It is not the purpose of the author to consider the local factors but to confine the discussion to the systemic factors which may influence the development of gingivitis.

The gums are affected in many obvious disease conditions, such as the various anaemias, scurvy and pellagra. From the public health standpoint, however, we are concerned with the development of gingivitis in the so-called normal individual. In the early years of the last war, examination of several hundreds of Royal Canadian Air Force personnel 19 to 25 years of age showed that mild but obvious gingivitis was present in no less than 20 per cent. These young men had already passed a rigorous medical examination and were considered to be in excellent health. They came from better than average homes from the economic standpoint. Yet one in every five suffered from involvement of the gums. Similarly, mild and moderate degrees of gingivitis are frequently encountered in otherwise apparently healthy children. In fact the author has observed these changes in infants under 2 years of age.

Smith, Persons and Harvie[1] have drawn attention to the fact that Chittenden and Underhill[2] in 1917 produced a disease in dogs by feeding a simple diet adequate in proteins and calories but deficient in vitamins A and D. The disease was characterized by anorexia, weight loss and a rapidly progresssive inflammatory process of the mucous membrances of the mouth. Goldberger and Wheeler[3] produced a similar disease by feeding a diet deficient in pellagra-preventive factors but otherwise adequate for nutrition. The oral lesions in both types of canine black tongue are the result of infection with fuso-spirochetal group of organisms, secondary to lowered tissue resistence. This would indicate that a deficiency of vitamins A and D will result in increased numbers of fuso-spirochetal bacteria in the mouth, the same findings as those the result of a diet lacking in certain members of the B complex. King[4] has reported the beneficial effect of treating Vincent's infection with nicotinic acid, one of the members of the B complex. Kruse[5] has found that the administration of ascorbic acid in large doses and over a period of many months produces a beneficial effect on the inflammatory changes in the gums. It is thus evident that a deficiency of a number of different nutrients may be factors in the development of gingivitis.

With the above information in mind a survey was made of the intake of many of the nutrients by the R.C.A.F. personnel. The intake of nicotinic acid and vitamin A was good. The intakes of thiamine and riboflavin were somewhat below the recommended daily allowances. However, the intake of ascorbic acid, or Vitamin C, averaged between 20 to 25 milligrams per day, in contrast to the recommended daily allowance of the Food and Nutrition Board, National Research Council, Washington, of 75 milligrams per day. It was therefore decided to give large amounts

of a number of the vitamins to selected individuals suffering from mild gingivitis.[6]

One hundred and twenty male personnel under 30 years of age suffering from a mild degree of gingivitis without complicating factors, such as persistent mouth breathing, gross malocclusion, devitalized teeth and partial restorations, were chosen. They were divided into four groups and observed over a period of five months. Group 1 received 375 mgs. of ascorbic acid daily; group 2 received 225 mgs. of niacin daily; Group 3 received 45,000 I.U. vitamin A, 1,200 I.U. vitamin D, 9.9 mgs. of thiamine, 9.9 mgs. of riboflavin, 225 mgs. of niacin, and 300 mgs. of ascorbic acid daily in three divided doses. Group 4 received a placebo three times a day. No other treatment was given during the period of study. During the 5 months' period, 27 men were lost from the study and the observations were completed on 93 of the original 120. Complete medical and dental examinations were made at the beginning of the study and at monthly intervals thereafter. The men all appeared to be in good condition physically and the medical examinations did not reveal any abnormalities. At the time of each examination the gingival tissues were photographed in color. Fom the dental examinations and a study of the monthly photographs, it was found that a certain number of the subjects showed improvement, some no change and others an increase in the swelling, redness and other signs of inflammatory reaction. The numbers showing improvement however were no greater in the groups receiving vitamin therapy than in the controls. It was obvious that the administration of large amounts of ascorbic acid alone, of niacin alone, and of vitamin A, vitamin D, thiamine, riboflavin, niacin and ascorbic acid over a period of 5 months produced no beneficial effect.

It was then decided to approach the problem from a different angle. As it has been common dental experience that gingivitis tends to recur after what would appear to be adequate local treatment, a study was undertaken to determine the effect of various levels of ascorbic acid intake on the recurrence of signs of inflammation of the gingivae among individuals who had received local treatment to remove as far as possible all clinical evidences of gingivitis. Twenty-two individuals who for 6 months were on a diet which supplied 62 mgs. ascorbic acid in the food, and 25 others on the same diet plus 375 mgs. ascorbic acid in tablet form daily showed less evidence of recurrence of inflammation than did a group of 29 individuals on a diet containing only 10 mgs. ascorbic acid in the food for the same period. The subjects who received the additional 375 mgs. showed no less evidence of recurrence of inflammation than the subjects receiving only food containing 62 mgs. ascorbic acid.

The results of this study were such as to indicate the desirability of repeating and elaborating the work. Accordingly, 150 R.C.A.F. personnel, all under 30 years of age, both male and female, were chosen for the study because all had a mild or moderate degree of gingivitis without other complicating factors, such as gross malocclusion, persistent mouth breathing, devitalized teeth or partial restorations. They were apparently normal individuals carrying on their regular duties. The individuals were divided into four groups and a color photograph of the lower anterior gingival region of each subject was taken. The individuals in all groups were then subjected to local treatment to remove as rapidly and completely as possible all the evidences of inflammation of the gingival tissues. Immediately after the local treatment had been completed the results were recorded and a second color photograph taken of the lower anterior gingivae. The four groups were then started on their respective diets. Group 1 received food containing approximately 10 mgs. ascorbic acid per day; Group 2, food containing 25 mgs.; Group 3, food containing 10 mgs. plus 70 mgs. ascorbic acid in tablet form, and Group 4, food containing approximately 75 mgs. ascorbic acid. Great care was taken to insure that the food served actually contained the desired amount of ascorbic acid. A special mess hall was set up where the group received their meals. In order to control the ascorbic acid content of the food, samples of all foods as served were collected for a 5-day period at 2 to 3 week intervals

through the 8 months of the study and were assayed for their free ascorbic acid content. Assays were done on approximately 25 per cent of all food served throughout the study. Even with this care it was found that the average ascorbic acid intake of Group 1 was 7.9 mgs., of Group 2, 22.3 mgs., of Group 3, 77.9 mgs., and of Group 4, 78.3 mgs. Clinical evaluations of bleeding and tenderness were made at monthly intervals, the examiners not knowing to which groups the subjects belonged. The tests for bleeding and tenderness consisted of pressure on the gums at the base of the papillae of the lower incisor teeth with a probe-like instrument having a smooth, blunt end 2mm. in diameter. The instrument was mounted inside a hollow handle and was so sprung that a pressure of one pound could be repeated at each application. The pressure was exerted at right angles to the surface of the gum tissue. If bleeding occurred the haemorrhage took place at the neighboring gingival margin. In regard to tenderness, the patient was asked whether or not the pressure caused pain. Usually however if the gums were tender the subject would wince and attempt to withdraw his head. Color photographs were also repeated at the same time as the clinical examination. At the conclusion of the study the photographs were evaluated for redness and swelling, again the examiners not knowing to which group the photographs belonged.

Fasting blood plasma ascorbic acid determinations were made on all subjects at the beginning of the study and at approximately monthly intervals thereafter. Those whose plasma ascorbic acid levels were either too high or too low as compared with the average of their respective groups were interviewed and an effort made to discover any dietary cause of the discrepancy. If unusual findings were obtained on more than one occasion, the subject was discarded from the study.

When the study was completed and the findings tabulated, the results were extremely interesting. It was found that in the individuals who had received the low average intake of 7.9 mgs. of ascorbic acid per day, redness, swelling, bleeding and tenderness recurred much more frequently than in the individuals who received food containing an average of 78.3 mgs. per day. In other words, the higher intake of ascorbic acid tended to prevent the recurrence of gingivitis. The results with the group receiving 22.3 mgs. of ascorbic acid per day stood midway between the very low intake and the recommended intake. The results obtained with the group receiving the recommended intake but largely in synthetic form were not as good as with the group receiving the same intake but supplied in the food consumed. This should not be interpreted as indicating any difference between the effect of synthetic and the natural ascorbic acid but rather that other substances in the food probably had a beneficial effect. From this study it would appear that a diet low in ascorbic acid predisposes the individual to the development of gingivitis.

Many studies on population groups in the northern part of the United States and Canada indicate that for many months of the year a considerable percentage of the population receives a daily intake of ascorbic acid far below the recommended allowance. From this it would appear that local treatment should be accompanied by dietary directions.

What directions should be given the patient? Ascorbic acid is the most easily destroyed of all the vitamins. It has been found that some cooking procedures cause the loss or destruction of as much as 95 per cent of the ascorbic acid originally present in the food. Hence the reason for including in the diet some raw fruit and raw vegetables. As far as vegetables are concerned, there are only four which are reasonably cheap and available throughout practically the whole of the year that supply reasonable amounts of ascorbic acid. These vegetables are potatoes, cabbage, turnips and tomatoes. Three and a half ounces of potatoes in their raw state (sufficient for an average serving) contain about 30 mgs. of ascorbic acid. However, during storage this is gradually reduced so that at the end of 8 months, or in the early spring, this amount contains only about 10 mgs.

If they are mashed or scalloped, practically

all the vitamin C is lost. Approximately 75 per cent is lost when they are fried. However, if they are boiled or cooked with their skins on, about 75 per cent or more of the vitamin C is retained. Three and a half ounces of raw cabbage contains about 50 mgs. of ascorbic acid. Fortunately this does not decrease on storage, but if the cabbage is cooked more than the minimal time and with the minimal amount of water necessary to produce a palatable product, a large proportion of the ascorbic acid is lost. Three and a half ounces of turnips supply about 40 mgs. of ascorbic acid. Not a great deal is lost in the storage of turnips or the cooking of turnips. However, turnips are not a favorite vegetable and are served at relatively infrequent intevals. The canning of tomatoes or tomato juice destroys only a small percentage of the vitamin C originally present. The three and a half ounces of fresh tomatoes or tomato juice contains approximately 18 to 20 mgs. of ascorbic acid, while the canned product usually contains about 15 mgs. Very little vitamin C is lost in the cooking of fresh or canned tomatoes. It is thus seen that tomatoes are a reliable source of vitamin C.

Many of the more expensive vegetables and fruits are excellent sources of ascorbic acid, such as fresh asparagus and other fresh green vegetables, strawberries, raspberries, canteloupe and melons. The best sources of vitamin C however are the citrus fruits. Three and a half ounces of orange juice supplies about 50 mgs., and the same amount of grapefruit juice supplies about 40 mgs. of vitamin C.

From the practical standpoint, unless the diet contains citrus fruit or tomato juice, the ascorbic acid intake is almost invariably less than half the recommended allowance. In order to insure an adequate intake of vitamin C, your patient should take each day a small glass (3½ oz.) orange juice or grapefruit juice, or a whole glass (7 oz.) tomato juice. In addition, it is advisable to take some raw vegetable, such as cabbage salad. If these directions are followed, along with a reasonable intake of other foods, the daily intake of vitamin C should reach the desired level, namely, 75 mgs.

In presenting evidence that a lack of ascorbic acid containing foods can be a factor in the development of gingivitis, it cannot be too strongly emphasized that no inference be made that this is the only factor involved in the production of this disease. As already mentioned, there are many local factors, but the work here presented does demonstrate that systemic factors must be considered. From the medical standpoint, probably no one thing so affects the health of both the child and the adult as the food we eat; not just food containing ascorbic acid but food which furnishes all the 40 nutrients essential for life. An adequate supply of these nutrients can readily be obtained. Build the diet around 1 to 1½ pints of milk daily, some meat, 4 to 7 eggs a week, 2 vegetables daily besides potatoes, some raw fruits, particularly citrus fruits, some whole grain cereal or enriched bread, and in the winter months some fish liver oil or other source of vitamin D. If this is done, our experience as pediatricians indicates that it will tend to maintain resistance against infection and to develop and keep the body tissues, including the gingivae, in a healthy state.

SUMMARY

Mild but obvious gingivitis is frequently encountered in individuals who appear to be in good health. The frequency with which this condition is seen even in children and young adults makes it of concern to both the dental and medical professions.

Both local and systemic factors are involved in the production of gingivitis. Evidence has been presented that one of the systemic factors may be a low intake of ascorbic acid.

There is evidence that a considerable proportion of the population of the northern part of the United States and Canada receives an inadequate intake of ascorbic acid during the winter and spring months.

An adequate intake of Vitamin C can be insured by the daily intake of 3½ ounces of citrus fruit juice or double that amount of tomato juice and some raw vegetables, such as cabbage salad. These foods along with any

reasonable diet will result in a daily intake approaching the recommended 75 milligrams.

No inference should be made that an intake of food low in ascorbic acid is the only systemic etiological factor in the development of gingivitis. From the nutritional standpoint, the food consumed should supply adequate amounts of all the 40 nutrients essential for life.

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NOTICE

Of interest to all who practice Dentistry for Children will be the following symposium to be held Wednesday, September 15, 1948, at the National Convention of the A.D.A., Stevens Hotel, Chicago.

"An Evaluation of the Class II Amalgam Filling in the Primary Molars"

9:30 to 10:10 A.M.

Phase 1. ***Structural and Morphological Considerations in the Preparation of the Class II Cavity for Primary Molars***

Essayist ..... Sumner A. Russman, D.D.S., M.S.
Discussant ..... George W. Teuscher, D.D.S., M.S.D., Ph.D.

10:10 to 10:55 A.M.

Phase 2. ***The Class II Cavity Prepared in Primary Molars to Secure Maximum Resistance to Masticatory Stresses and to Utilize the Physical Properties of Silver Amalgam***

Essayist ..... William E. Brown, Jr., D.D.S.
Discussant ..... Alfred E. Seyler, D.D.S.

11:00 to 11:40 A.M.

Phase 3. ***Selection of the Matrix and the Clinical Manipulation of Silver Amalgam in Filling the Class II Cavities of Primary Molars***

Essayist ..... E. Carl Miller, D.D.S.
Discussant ..... Miles Markley, D.D.S.

Summary of entire session by Kenneth A. Easlick, A.M., D.D.S.

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Southern California Reports

Here, outlined in brief, are the highlights of the regular monthly meetings of the Southern California Unit, American Society of Dentistry for Children:

JANUARY

The occasion was the first meeting of the Southern California Unit under its 1948 corps of officers, as follows:

President . . . . . W. W. Demeritt, D.D.S.
Vice-President . . . . Clara A. Carbinier, D.D.S.
Secretary-Treasurer
Francis W. Summers, D.D.S.
Immediate Past President
Niels B. Jorgensen, D.D.S.
Directors, 1948 . . . Harold W. Barnes, D.D.S.
Arthur L. Everett, D.D.S.
Directors, 1949 . . . . . Edwin L. Potts, D.D.S.
Ted Gettinger, D.D.S.

The dues of this branch have been raised to $12.00 per year.

We honored at this first meeting of 1948 our Honorary Member, Dr. M. Evangeline Jordan, who is known as the "Pioneer of Children's Dentistry." She was the first Pedodontist in the United States and is the author of the first book published on the subject "Operative Dentistry for Children." This book, since translated in French, Spanish and Japanese, appeared in serial form in "Dental Items of Interest" in 1921.

At the last meeting of 1947, we had a very outstanding program: John Wilcox, M.D., Pediatrician, Claremont, California, spoke to us on "Infection and Rheumatic Fever." Also, on the same program, was Harlan Apfel, D.D.S., Oral Surgeon, San Pedro, California, who presented slides and his treatment "Immediate Replacement of the First Permanent Molar with a Live Third Molar Tooth Bud," and "Surgical Intervention to Promote Cuspid and Biscuspid Eruption." There was a large attendance.

Stressing the variations from the accepted procedures in handling adult patients, Berto Olson, D.D.S., F.I.C.D., discussed "Anesthesia and Surgery as it pertains to Dentistry for Children."

FEBRUARY

Barold R. Riedel, D.D.S., Supervisor, Dental Section, Health Service Branch of the Los Angeles City Schools, spoke to us on: "Dental Education in the Los Angeles City Schools."

Dr. Riedel is an alumnus of Iowa State University and has been with the Board of Education in Los Angeles since 1939. His message of Dental Education and Preventive Dentistry as it is taught in our schools was of interest to every member of the profession.

Also on the same program we were privileged to hear our own James Robinson, Executive Secretary of the Southern California State Dental Association, give us much to think about when he discussed "The Horizon of Dentistry for Children."

MARCH

The topic for this meeting was "When Should the Dento-Facial Anomaly be Treated?" and was a symposium on the analysis of conditions which contribute to the present day controversy in orthodontic therapy. Types of orthodontic cases that respond to early treatment and those which require observation and treatment at a later age level as well as the etiology and contributing factors that create these Dento-Facial anomalies were discussed by three outstanding Orthodontists, Dallis R. McCaulley, D.D.S.; Fred E. McIntosh, D.D.S.; Ben L. Reese, D.D.S.

The Southern California Unit sponsored a group of table clinics at the afternoon session, February meeting of the Los Angeles Dental Society, as follows:

Eugene Ziegler, D.D.S.
"Pre-Natal Counsel"
Ted Gettinger, D.D.S.
"A Pleasant Office"
William Demeritt, D.D.S.
"Voice Control"
Samuel Bocarsky, D.D.S.
"An Unmanageable Child and Parent"
Harold Sturgeon, D.D.S.
"Tooth Ache"
George J. Higue, D.D.S.
"Acute Abscess"

Ruth Pelton, D.H.
"Mouth Care"
Carlotte Huber, Dental Assistant
"Radiographic Technic"
Herbert S. Adair, D.D.S.
"Radiographic Interpretation"
Francis W. Summers, D.D.S.
"Photography"
Niels Jorgensen, D.D.S.
"Local Anesthesia and Sedation"
Mulford Smith, D.D.S.
"Interosseous Technic"
C. Park Scott, D.D.S.
"Vincent's Stomatitis"
Edwin L. Potts, D.D.S.
"Class II Cavity Preparation, Primary Teeth"
Howard Daniels, D.D.S.
"Teeth Misplaced or Lost Due to Accident"
Gordon Rucklos, D.D.S.
"Fractured Teeth Without Pulp Exposure" Exposure"
Jean Setzer, D.H.
"Oral Prophylaxis"
Alvin Larson, D.D.S.
"Class III, Cavity Preparation, Primary Teeth"
Rex Waggoner, D.D.S.
"Matrix Bands and Retainers"
Elsie Schildwachter, D.D.S.
"Copper Amalgam Restorations"
G. Vernon Crandall, D.D.S.
"Silver Amalgam Restorations"
E. Clark Hubbs, Jr., D.D.S.
"Polishing Restorations"
Rudolf Jacobsen, D.D.S.
"Pulpotomy"
Edith Strauss, D.D.S.
"Pulpectomy, Vital Pulp"
W. A. Tully, D.D.S.
"Pulpectomy, Putrescent Pulp"
Raymond Contino, D.D.S.
"Restoration of Fractured Anterior Teeth with Three-quarter Crown"
Clara Carbinier, D.D.S.
"Join the Promotion of Dentistry for Children"
Joseph Herbert Vincent, D.D.S.
"Restoration of Fractured Anterior Teeth with Acrylic Crown"
C. Thomas Havey, D.D.S.
"Anterior Bridge for Primary Dentition"
James Pianfetti, D.D.S.
"Partial Dentures"
J. Clifford Willcox, D.D.S.
"Correction of Habits Causing Maloclusion"
Rodolfo Montes, D.D.S.
"A Simple Method for Correcting Locked Anteriors"
Alfred Rouda, D.D.S.
"Space Measuring"
A. L. Anderson, D.D.S.
"Crib Type Space Maintainers"
Don Chatterton, D.D.S.
"Inlay Attachments for Space Maintainer Abutments"
Max Gatov, D.D.S.
"Common Problems of the General Practitioner and Orthodontist"
Roy Bourquin, D.D.S.
"Nutrition"
S. A. Anderson, D.D.S.
"Schneider Test for Caries Susceptibility"
Clair, Lombard, D.H.
"Recall Records"
Harold Barnes, D.D.S.
"Public Health Dental Programs"
Alexander White, D.D.S.
"Textbook on Dentistry for Children"
Elsie Schildwachter.

Attend our National Meeting
September 11, 12, 13, 1948
Chicago—Hotel Stevens
AMERICAN SOCIETY OF DENTISTRY FOR CHILDREN

BOOK REVIEWS

Radio Manual, published by Oral Hygiene Committee of Greater New York, 111 East 56th Street, New York City. Price $4.00.

A volume of 50 talks, or broadcasts on dental subjects of interest to the general public or the dentist who is seeking suggestions for radio presentation of talks to lay audiences. Dentistry for children occupies a prominent place in this volume and although certain portions of several of the talks are "dated" as it were, and are not based on proven scientific data, the material is written in a style which is for the most part, readily understandable by the lay audience.

This book should be in the library of all dental societies—and its use by the Council on Public Health and Education of these societies is a "must".

Dentistry for Children by John Charles Brauer, L. B. Higley, Maury Massler, and Isaac Schour. Blakiston Company, Philadelphia. Second edition, 417 pages illustrated.

According to one prominent and well qualified teacher of pedodontics, the best definition for most textbooks of dentistry is "Tomes in which dead knowledge is buried." And by and large this statement has basis in fact, for a critical survey of the textbooks used by many of our teachers of dentistry will reveal statements or opinions of authors expressed or implied as being facts, many of them completely innacurate in the light of recent research or accurately compiled statistical evidence.

Dr. Brauer's text seems to be, however, an exception, for it is an interesting, well-written and highly readable compiliation which expresses well the personal characteristics of himself and his co-authors, as known to this reviewer. Preciseness and attention to detail and authenticity of statements are everywhere evident in the book, well supported by a bibliography at the end of each chapter.

In the first chapter of this book, much statistical, yet readable, data are presented on the subject of the incidence of dental caries in children and cleverly used to present further evidence that dentistry for children is an essential part of the dentist's obligation to his fellow men, and that the discharge of this obligation can be handled to the financial and physical good of patient, parent and dentist. A succinct analysis of the author's ideas on dentistry for children is found under "Operative Skill"—"Poor workmanship in terms of unsatisfactory results cannot be overshadowed by a high-powered personality. There is no substitute for good operative skill."

In a single chapter, Dr. Brauer rather completely and interestingly discusses the many types of child behavior problems which present to the general practitioner, together with common sense suggestions for the handling of parents and patients whose psychologic development has not been optimum from the dentist's standpoint.

Not pedantically, but thoroughly, the chapter titled "Development of the Teeth—Normal and Abnormal" by Isaac Schour and Maury Massler, will serve as an up-to-date reading assignment for either student or dentist. The illustrations and tables are excellent and presented at intervals to make them an adjunct to the written text. Factual comments and discussions are found on questions that arise in the average dental office, ranging from the normal to the abnormal dentition or individual teeth and including short observations on such occurrences as difficult eruption and bruxism.

The primary teeth are discussed from the morphological and histological point of view in Chapter 4, and here again, the laboratory findings are worked into helpful explanations of phenomena that are seen by any dentist in the mouths of his child patients.

"Preventive Orthodontics," as discussed by Dr. L. B. Higley, is an excellent compendium of growth and development facts concerning the head and jaws, with suggestions for the prevention and correction of harmful habits, together with the etiological factors. Several simple orthodontic appliances which will be of value to the general practitioner for space maintenance or the correction of "locked" permanent anterior teeth, are described with their construction and indications discussed.

Chapter 6 presents an authoritative summary of the latest theories and findings on dental caries, discussing etiologic, nutritional, vitamin, carbohydrate and salivary factors, together with the latest information on current methods for prevention and control.

To round out Part I of Dr. Brauer's book, Massler and Schour present a review of frequently seen mouth lesions and infections with suggested treatments, a discussion of nutrition and oral diseases with considerations of diet, vitamins and minerals. The endocrine glands are discussed rather minutely as to their function in jaw and tooth development, with laboratory features well illustrated.

Part II of "Dentistry for Children" embraces the technical procedures in pedodontics. A comprehensive chart and record for every child patient examination is advocated by the author. While it is agreed that all the information sought on these records would be desirable, it is doubtful if many pedodontists, much less general practitioners, will feel inclined to pursue the procedure in their own office. For teaching, clinic and research projects however, much more information is regarded as essential, and for such purposes the detailed examination is well described.

The chapter "Operative Dentistry for children" emphasizes cavity preparations for the usually needed types of restorations, together with discussions on cavity linings, matrices, amalgam and cast inlay restorative materials.

The average reader will be well repaid for his time and careful consideration of Dr. Brauer's chapter on "Pulp and Root Canal Therapy in Primary and Permanent Teeth," for it is a comprehensive, readable and practical treatise on the subject. Your reviewer liked this summation, "A pulp capping, a pulpotomy or a pulpectomy is an attempt on the part of the practitioner to treat and save a tooth that is otherwise destined for extraction. If one can realize 25% success in the treatment of such teeth, it is considered a worth while procedure. However, experience shows that in selected cases the percentage of success will be at least 75. It is therefore logical to expect some failures, and the wise practitioner will have the parent fully prepared for such an event. The physician does not guarantee to cure a disease or keep alive a patient, but informs those concerned that it will be his objective to do the best he can under the circumstances. It is with this philosophy that pulp and root canal therapy for the child should be attempted."

Space maintenance and treatment of fractured anterior teeth receive detailed attention in chapters 15 and 16, with a discussion of the need and indications for the insertion of space maintainers of several designs. In the chapter on fractured anteriors, your reviewer would like to have seen a dissertation on the modified acrylic shoulder-less jacket crown in addition to the less esthetic restorations described.

"Oral Surgery for Children" titles the final chapter in Dr. Brauer's book, presenting topic headings such as "Special Considerations in Oral Surgery for Children," "Child Management" and "Anesthetics," including general anesthesia.

Every dentist who does any dentistry for children, and every teacher of pedodontics will welcome Dr. Brauer's book and to him and his co-authors, Doctors Higley, Massler and Schour, this reviewer says "Well done!"

A. E. S.

Attend our NATIONAL MEETING
SEPTEMBER 11, 12, 13, 1948

CHICAGO — HOTEL STEVENS
AMERICAN SOCIETY OF DENTISTRY FOR CHILDREN

A Dental Bill of Rights for Children

DANIEL F. TOBIN, D.D.S.*

When the story of the present period of dentistry is studied by future generations, let us trust that great strides toward true prevention of dental disease will be its distinguishing feature. Dental research today is working toward specific prevention, both pharmacological and physiological. If the results bring disease within the limits of the control the family dentist can exercise, it will be the real progress for which we have long hoped.

In the meantime we must continue to use our current methods of treatment and control of caries, periodontal disease and deformities of occlusion. It is common knowledge that we have not as yet reached a level of optimal use of these measures. As dentists interested in the welfare of children, it is rightfully our concern to improve upon this situation both within the profession and in our relations with other health agencies.

A suitable beginning in that direction would be to list the mature thoughts of practical dental health considerations to which our children should be entitled. I have taken the liberty to call that list, "A DENTAL BILL OF RIGHTS FOR CHILDREN:"

FIRST: The right to *very early* attention to the factors contributing to dental disease and deformity, and to *continued periodic recall care.*

SECOND: The right to treatment on a par with that accorded adults.

THIRD: The right to recognition of dental needs of children on a par with the recognition of their other health needs.

FOURTH: The right to inclusion of dental health education and treatment as a part of the child's formal education.

FIFTH: The right to full benefits from the total knowledge of how to establish and maintain dental health.

*Director, The Murry and Leonie Guggenheim Dental Clinic, New York, N. Y.

How early can dental disease and deformity be influenced? The answer to this question must be at least in part speculative since our knowledge of etiology is far from complete. Physiologically, the human body is a steadily changing system of small interrelated worlds making up a veritable universe within itself. From conception to advanced old age hardly any part is untouched by the constant transitions of growth and development, dissipation and repair. The oral cavity, as part of this system, is especially liable to chemical, bacterial and traumatic injuries, while lacking in some respects, the reparative potencies of other parts.

As *caries* is concerned primarily with enamel, it is important to note that calcification of the primary dentition begins about the 5th month of pregnancy and terminates about the 12th month after birth. Thus, the external enamel of the primary teeth is formed postnatally. The permanent teeth begin calcification at birth and therefore are subject to influence postnatally, too. It can be concluded from these facts that control and protection of enamel of both dentitions begins at birth. Normally, in the presence of a fair amount of cooperation, very little dental disease should affect the child from birth to school age. Yet, in repeated surveys of preschool children at the Guggenheim Dental Clinic, it is evident that decay starts very early and progresses rapidly until at 6 years of age almost all children show caries of varying intensity and extent.

Malocclusion, on the other hand, with the exception of true hereditary influences, can be initiated prenatally. The history of a mother's period of pregnancy reveals the presence or absence of possible injurious agents capable of deranging the pattern of growth of the foetus and thereby the ultimate character of growth of the child. Sved in his writings on the etiology of malocclusion describes the

theory of "feebleness of growth" as originated by Jansen, an orthopedist. He plausibly presents the concept that overwork, fatigue, lack of the feeling of well being and other factors lowering the level of health of the mother can directly reflect in the character of general growth of the child, of which the growth of the jaws is a part. Evaluation of the reported work of Milo Hellman on the correlation of growth types of children with the various divisions of the Angle's classes of occlusion supports Jansen's theory unwittingly as does the work of Broadbent and Simon on the relative percentage of face growth achieved by birth.

Periodontal disease, while only rarely present in advanced degree in children, does manifest itself more commonly than has been reported in the form of gingivitis. In addition to the immediate benefits derived from its treatment, prevention of its establishment in chronic recurring form may well remove the foundation for periodontal disease in early adulthood.

Therefore to insure early care:

Prenatally—Good general health care and guidance for the mother.

Infancy—Good health and nutrition for the infant; correct mouth habits.

Primary Dentition—Good nutrition, oral hygiene, visits to the dentist and mouth habits correction.

Mixed and Secondary Dentitions — Continued periodic recall care and guidance.

The right to treatment on a par with that accorded adults places the responsibility for lack of adequate dentistry for children directly on us as dentists. Increased undergraduate and postgraduate facilities in pedodontics are slowly affording children this right together with more public and private clinics. Soon such practices as silver nitrating cavities instead of filling them, filing carious approximal surfaces in the manner of aborigines as a substitute for filling, use of inadequate temporary fillings in place of indicated types of permanent materials, retention of chronically abscessed teeth as space maintainers and complete neglect of primary teeth on the premise that they will soon be lost, will be eliminated from the American dental scene.

Still in many places this treatment is accorded children today. Much of it is due to lack of understanding of the child patient and how much cooperation he can give in receiving proper treatment. Wide use of radiography, careful local anesthesia, skillful operating and all the solicitude in the avoidance of fear, pain and discomfort characteristic of our work for adults will assure gratifying results in children.

In comparison with the recognition of the other health needs of the child, its dental needs are too often totally neglected even while hospitalized for long periods when dental treatment is possible. If dentistry can be made an effective working part of the obstetric and pediatric services of hospitals, it can very strongly influence the future direction of child dental health. Medical schools and hospitals can well utilize the knowledge and skill of dentists as workers, teachers and consultants. Many chronic disease hospitals and institutions are virgin fields for men with training and interest for contributing to pedodontics. If we seek and are granted these positions, by our efforts dental needs of children will gain recognition and importance.

The right to the inclusion of dental health education and treatment as a part of the child's formal education originates from two facts: (1) the school is rightfully the place for teaching the subject of health and (2) all the needed dental care cannot be rendered after school and on Saturdays, holidays and vacations. The connection between these two facts is the acknowledged approval by enlightened educators that dental treatment is an important phase of health education and may be performed during school hours.

With the supplementary aid of prophylaxis service by hygienists in the schools, teachers can effect good dental health guidance by promoting good oral hygiene and sound nutrition as desirable for health, appearance and beauty.

Finally, the right to full benefits from the total knowledge of how to establish and maintain dental health is essentially the goal of organized dentistry. We are progressing in that direction within the profession through improved teaching, research, and the forging

of composite orthodox opinion through the workshop method; and outside our professional boundaries our influence is strengthening in its effect upon education, medicine, the press, government and the people as a whole. Health is everybody's job in part, at least, and in the case of children it is so to a greater degree.

While pursuing the course of solution to the many problems of dental health for children, it is important that we avoid tangential detours by viewing innovations critically and holding on to the security afforded by our accepted and time tested orthodox procedures, especially whenever preliminary reports of new measures show promise.

In brief summation, to children we owe the best planned, considerate and skillful treatment and guidance; to dentistry, the obligation to do our utmost to achieve these ends.

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American Society of Dentistry for Children

"To stimulate greater interest in dentistry for children in the United States; to create an enthusiasm and spirit of cooperation in other countries throughout the world; to advance and disseminate to the profession and the public a knowledge of all phases of pedodontics."

I hereby apply for membership and promise to abide by the Constitution and By-Laws of the Society.

Name_____

Address_____ ***Zone***_____

City_____ ***State***_____

Enclose annual dues of $3.00. Where a State Unit exists, this application will be referred to the local Secretary for further correspondence.

A. D. A. Member ☐
C. D. A. Member ☐
General Practice ☐
Orthodontist ☐
Pedodontist ☐
Public Health Official ☐

EARL L. LAMPSHIRE, D.D.S., *Secretary*
708 Sharp Building
Lincoln 8, Nebraska

AROUND THE COUNTRY

Gee, you folks were good to me this issue. Just lots of personal news. However, there are still a few units we would like to hear from, and if time permitted, your reporter would hop in his old Ercoupe and pay a personal visit to each and every unit! But take it from me, postage is much less expensive!

Our Alberta Group is certainly on the beam. Just organized a short time ago, they have been 100% in their reporting to me. Writes *Dr. R. H. Blaquiere:* "We have had quite a successful winter with some excellent papers by members of our group. We are using excuse slips for school children patterned after the one you sent from Michigan. The last few meetings have been devoted to working out a schedule of studies. (Remember, this group has a most ambitions study group plan laid out.) We plan to have one basic science subject and one practical subject at each meeting. In this respect, we certainly would appreciate any information as to the activities of other groups to be used as a guide for ours."

In these two groups of subjects there are listed twelve under Basic Science, and nineteen under Practical Subjects. Even our schools might get an idea or two from this long list of Practical Subjects. Yes sir, these boys and gals in Alberta are really setting a pattern for us!

Now let us go down to sunny Texas. From *Paul Taylor,* Past Pres., now a good reporter, comes the following:

The annual meeting was held in Fort Worth with *Dr. Glen Hillin* presenting a paper on "Indications for the Early Removal of Third Molars," which was formally discussed by *Dr. Earl Williams* and followed by an interesting discussion. Both *Drs. Hillin* and *Williams* practice in Dallas, Texas.

Dr. Ben Kletzky of Denver, attracted the family practitioner with his subject of "The Practice of Children's Dentistry." *Ben* really "packed 'em in." Well over a hundred stayed for the full day's program.

The following new officers were elected. President, *Dr. Lee E. Blackwood* of Corpus Christi; V. Pres., *Dr. Byron N. Coward,* Corpus Christi; Sec.-Treas., *Dr. John Powers,* Wichita Falls.

Just ran across a card I received from Boss *Al Seyler* some time ago. He tried to make me believe I was to give the "Editorial Report" at the Boston meeting. And I almost fell for the idea! We all know that my boss will soon be "our" boss, since *Al* is to be our new A.S.D.C. President. You can take it for what it is worth from your reporter, that *Al* is "tops." He has been under the guidance of *Walter McBride* for years, but has developed his own personality to the extent that we can have but one *Al.* Just try to repeat one of his stories at a mixed gathering and you will understand what I mean.

Al was our guest of honor and speaker at the annual meeting of the Michigan Unit, held in conjunction with the Michigan State Society meeting in Detroit. It was the privilege of your reporter to sit at the head table with him and enjoy watching his knees bump together just like any other ordinary guy who might be honored. Yes, sir, folks—*Al* will make us a fine President.

From Pennsylvania, our good friend Gertrude Tank sends your reporter a card, but sends a long news letter to *Pres. Mott!* After many postage stamps I finally get the low down from *Mott,* so here it is. *Dr. Nelson,* Professor of Pediatrics at Temple University, was headline speaker for one of the Unit's meetings. The P.S.D.C. Unit plans a joint meeting with the Pediatric Society, and has elected the following new officers: President, *Dr. Horace Githens;* Pres. Elect and Chairman of the Program Committee, *Dr. Gertrude Tank;* Sec.-Treas., *Dr. Edward Cherkas;* Membership Committee, *Drs. Morris Kelner,* Chg., *Jay Eshelman, John H. Yearick.*

And now, by golly, I get a letter (3c stamp too) from Gertrude. She gives me "hail Columbia"—or in her own words, "Shame on you, Dr. Brown! You certainly put me in the stock for misbehavior in the last Journal." Here and now, Gertrude, I apologize. No intent on my part to put you in the "dog house" but just trying to save you postage!

Nebraska, where the tall corn grows—if they have rain. Your reporter has a brother-in-law living in *Ralph Ireland's* home town, Lincoln. A big "pow-wow" at the Fontenelle Hotel. "Topical Fluorides" and *Dr. Henske,* M. D., Chief of Staff at Children's Memorial Hospital. Now really *Arlo,* I would like to report the names of your new officers but the only information I have is "Election of officers. Important meeting." Why not let us all in on this? I *can* report that *Dr. Arlo Dunn* is Sec'y-Treas., because he sent me the above news. What about your other officers, *Arlo?*

I did not dare go direct from Texas to California, but here is a report from one of our star reporters, *Charles A. Sweet, Jr.,* Oakland, California. (Don't know *Junior* too well, but he sure has a swell Dad.)

Dentistry for children played an important part in the State Association meeting. *John Brauer,* from Washington University, put on an excellent program, speaking on many phases of Dentistry for Children before a large audience. Besides being an able speaker and a leader in the field of Dentistry for Children, his extremely pleasing personality and charm made him the highlight of the Convention. California will always be grateful to *John Brauer.* (These are the words of *Charles, Jr.,* but your reporter can concur.)

The "old master," *Charles, Sr.,* spoke on "Preventive Orthodontics," which gave all the boys plenty of food for thought. As *Charles, Jr.,* says, "We family practitioners were given a lesson which prepares us to give a better service to our patients." And after all, is this not the objective of all dentists?

John Hughes gave a clinic on Cavity Preparation and Toth Guidance, while *Chuck Sweet* presented "Vital Pulpotomy Technic for Primary and Young Permanent Teeth." Both clinics created a great deal of interest—ample evidence that both *John* and *Chuck* did outstanding jobs.

"The Treatment and Care of Injuries to Young Permanent Teeth" was most capably handled by *Ed. Randal, Sam Brown, Francis Bushness* and *Olgo Gariaeff.*

"Patient Management" was very well presented by a newcomer, *Stan Gray,* who is specializing as a pedodontist. *"Windy" John Hughes, "Shorty" John Sowden, "Silent Earthquake" Chuck Sweet* and *"French Impression" Louis DeMeo,* attended *Charlie Sweet, Sr.'s* four day course in Tooth Guidance. (Note—with all the special handles attached to the several "students" one would think a good time was had by all.)

Chuck reports that we will hear more about young *Carl Ellertson* (another Jr.) and his fine work on "Morphology of Pulp Chamber in Primary Teeth."

Please—Just a word from your column reporter. If all you Unit reporters would come across like *Chuck Sweet,* we would have news! You boys from Texas, Michigan and elsewhere better come across, too.

A penny post-card from *Walter McBride,* confessing he has read the last issue of our Journal. Look out, boys, Mac has a trump card up his sleeve—but you may have to find the card at any drug store or at a book store Too good to be published by a scientific publishing house. But keep your eyes and ears open. *Walter* will have something worth while to read—soon.

Your reporter hopes that all of you have received a copy of the material presented by the Bureau of Health Education, Jefferson County Department of Health, Birmingham, Alabama. Also, did you know that *Alyce Walker* reported to the natives a swell build-up on "Preventive Dentistry is a Great Step Forward." The Jefferson County Health Department is out front in the nation-wide fight against tooth decay in children.

Here and There—

By golly, *Sam Stulberg* is the father of a "new" baby boy, *Robert Bruce* by name, who

was born in the merry, merry month of May. Congratulations, *Sam!*

Dr. Duane Madison of Herkimer, New York, a member of our N. Y. Unit, attended the 25th Anniversary of his class at Ann Arbor, June 10-11. *Duane* said that the old school "ain't what she used to be!" He also added that the Pretzel-Bell is nice, but give me Joe's and the Orient.

Southern California Branch A. S. D. C. presented for their April program, "Techniques of Hypnosis for Therapy" by *Mr. Charles E. Cooke,* the author of the popular Cooke Hypnotizing Spiral.

Michael Cohen of Boston is a busy man these days. For several months he has been most active in the organization of a Children's Dental Clinic at the New England Medical Center, and is now Acting Director of the Clinic. The objective of the clinic is to train young dentists to care for the complete needs of the child including simple orthodontics.

Our A.S.D.C. members did a good job at the June meeting of the American Association of Dental Schools, held at Buffalo, N. Y. Participating in the program were the following: *John E. Gurley,* U. of California; *Maury Massler,* U of Illinois; *H. A. Zander,* Tufts College; *Eugene J. North,* U. of Buffalo; *H. A. Addelston,* N. Y. University; *George W. Teuscher,* N. W. University; *Virgil M. Cheyne,* State U. of Iowa; *H. M. Marjerison,* Forsyth Dental Infirmary; *J. O. McCall,* Guggenheim Dental Dispensary, *Phil Blackerby,* of the Kellogg Foundation.

Ad-Libbing by Your Reporter—

South Dakota made a survey about Sodium Fluoride with the following results: 1) Seven out of ten dentists use the treatment in their offices. 2) The majority make the applications in twenty minutes (exclusive of prophylaxis). 3) Average fee for prophylaxis and four treatments is $10.00. 4) Of dentists not using treatment, one-third are not convinced that it has any value; one-fourth are not familiar with the technic for making applications. 5) Sixty per cent of the dentists were in favor of permitting hygienists, assistants or nurses to administer the treatments.

Certainly protective and preventive measures are our only hope of reducing the accumulated dental needs. We should welcome with open arms and heart any ray of sunshine which gives us a light upon a dark subject, so to *John Knutson* (U.S.P.H.S.), your reporter says, "Keep plowing ahead."

From Pennsylvania—

Dr. Oborn G. L. Lewis of Saint Davids, who died May 7th after a prolonged illness, was the first President of the Pennsylvania Unit, A.S.D.C., and of course a charter member of the Unit. He was greatly responsible for the Unit's prestige through his interest and contributions to the Society. Due to illness he retired from active membership and was made the first Honorary member of the Pennsylvania Unit. *Dr. Lewis* was Professor of Operative Dentistry at the University of Pennsylvania and was associated with its Dental College from 1919 until his retirement in 1933. He was an excellent practitioner, an outstanding teacher, and will be greatly missed by those who knew him.

Bill Brandhorst has completed his graduate studies and is now associated with his illustrious father, *Otto,* in the practice of Orthodontics at St. Louis. Congratulations are in order for both of them—and our best wishes for their continued success.

Dean Robertson, formerly a member of our Texas Unit, has opened offices in Oklahoma City, Oklahoma, where he will practice pedodontics exclusively. Good luck to you, *Dean,* and how about looking us up at the A.S.D.C. meeting in Chicago this September?

Past-president *Ralph Ireland* was the featured speaker at the Pacific Coast Dental Conference held at Utah early in July. *Raf* has undertaken the job of promoting the Children's Dental Health Day in Nebraska, and has tentatively scheduled the date as Monday, February 14, 1949.

A.S.D.C.'er *Helmut Zander,* who assumes full professorship at Tufts, come September 1st, will head the newly created department of Pedodontics at that school. (I understand from *Editor Al* that *Helmut* has a very attrac-

tive wife!—Isn't it true that the glabellate guys always notice or rate the gals?!!)

George Teuscher, the big man in Pedodontics at Northwestern, appeared on the program of the Mississippi State meeting at Biloxi in June.

Dean Noyes, of the University of Oregon School of Dentistry, advises me that *Dr. Theodore Suher,* who received his M.S.D. in Pedodontics at Northwestern, will assume an Assistant Professorship in Pedodontics at the Oregon School. Good luck out there, *Ted*—but be careful of those twisted stogies your boss, *Hal,* smokes!

Joe Volker, who will leave the deanship of Tufts Dental College shortly to assume a similar position at the new Alabama School of Dentistry, left for Europe June 25 to participate in a comprehensive teaching project sponsored by the Unitarians.

Gene North, of Buffalo, was genial host to the pedodontists who attended the 25th Annual Meeting of the American Association of Dental Schools in Buffalo late in June. A luncheon was arranged for the group at Children's Hospital, where *Dr. Groth,* Dean of the Buffalo Dental School and *Moir Tanner,* Hospital Superintendent, welcomed the visitors and explained some of the details of the hospital organization.

Ken Easlick advises us that *Joe Hartsook* is now an Assistant Professor of Pedodontics at the University of Michigan. Congratulations, Joe, and perhaps some of these days you'll be taking trips like *Ken's* out to Wyoming, where, according to *Ken,* life is full of friendly folks, good bourbon liquor, cocktail parties, fine food, a little sleep and some pedodontics! I guess the *Peltons,* the *Ray Taylors* and *Pokey Arnold* really showed their Michigan guest a wow of a time!

Hugh Kopel, of our Michigan Unit has opened new offices in Detroit, and will specialize in Pedodontics, having recently passed the Michigan Specialty Board examinations. Good luck, *Hugh,* and hurry up with that new book on which you are collaborating!

Ernie Ritsert, of our Pennsylvania Unit, appeared before the dental society of Kane, Pa., during June, doing his usual good work in the presentation of his favorite subject, "Pedodontics." Do you still remember the ride in from Willow Run to Detroit last winter, with *Roy Brooks, Ernie?*

Jim Taub, of Albany, has moved his offices to larger quarters downtown, at 287 State Street, where he now works in air-conditioned comfort on these hot summer days.

From *Elsie Schildwachter* and husband, *K. I. Lewis,* we had a note last week, telling us about *John Brauer's* set-up in the new Washington School. "It's simply out of this world," says *Elsie,* so I guess we'll have to plan a trip to the far West to find out about this dream project for ourselves! *Elsie* and *K. I.* are having a fine vacation—but both are figuring on larger sized girdles when they return home!!

R. Duane Hayes has moved to Columbus, Georgia, where he has assumed the Directorship of the Columbus-Muskogee County Health Department. *Duane* has an ambitious program lined up for the coming year—but we promised to let him tell you about it in Chicago at the National Meeting.

New York:

Under the auspices of the New York State Department of Health a refresher course in children's dentistry was given at the New York University College of Dentistry, June 1 through June 11. Nineteen dentists from upstate New York attended the lectures, technique courses, and clinic sessions in this course, which were given by *Harold Addelston, Dave Ast, Martin Valentino, Sam Hemler, Dean Walter Wright, Sidney Finn, Harold Klein, Sid Kronfeld, Sam Miller, Arthur Thomas, Irving Gelston, Leo Winter* and *Neal Chilton.*

It is courses like this, designed for postgraduate education of the general practitioner, which are the basis of more and better dentistry for children. Here's a pat on the back for each of you enterprising New Yorkers!!

This department is conducted by Stan Brown. Please direct items of interest to him at Ithaca, Michigan.

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